VERMONT

Universal Medical Evaluation/Progress Report

Department of Motor Vehicles
Agency of Transportation

120 State street
Montpelier, Vermont 05603-0001
802.828.2000
888.99-VERMONT
dmv.vermont.gov

****THIS EVALUATION MUST BE COMPLETED IN FULL OR IT WILL BE RETURNED****

ANY MEDICAL CHARGES INCURRED ARE THE RESPONSIBILITY OF THE PATIENT

Indicate Reason for Evaluation

Complete Sections A, B, D & E if you are selecting one of the four reasons below. See front and back of form.

- ❑ Applying for a Vermont License/Permit
- ❑ School Bus Endorsement (Type II)
- ❑ Department Request
- ❑ New/Update Medical Condition

Complete ALL Sections if requesting a DISABLED PLACARD OR PLATES. See front and back of form.

- ❑ Disabled Parking Placard (must also submit a completed Disabled Parking Placard Application ~ VD-120)
- ❑ Disabled Parking Plate (must also submit a completed Registration, Tax and Title Application ~ VD-119)

** Parking Placard Applicants: The Information In This Medical May Be Considered In Determining Your License Status**

SECTION A - To Be Completed By Applicant

Patient's Name:	
Patient's Mailing Address	
Physical Address	

Check If The Above Is A Change To Your: ❑ Mailing Address ❑ Physical Address

Gender	Date Of Birth	Social Security Number	VT Driver License/Id Number

If This Is A Name Change, List Former Name:

I certify that the information contained above is true, complete and correct to the best of my knowledge. Statements and warrants herein are certified under penalty of 23 V.S.A. §202 & §203.

➢ APPLICANT'S SIGNATURE:

SECTIONS B, C, D & E – To Be Completed By Medical Examiner

SECTION B

1. Patient has been under my care for _____ years.
2. Check any of the following conditions that apply:

❑ Seizures	❑ Cancer	❑ Spinal Injury	❑ Hypertension
❑ Diabetes	❑ COPD	❑ Arthritis/Degenerative Joint Disease	

❑ Amputation: Arm: ❑ Left ❑ Right Leg: ❑ Left ❑ Right Describe cause and extent (example: at elbow, below knee) of amputation: ❑ No Applicable Conditions (N/A)	❑ Permanent Disability/Condition: Specify:	❑ Psychiatric Disorder: Specify:

3. Blood pressure reading is required for **all school bus driver medicals**. For other licensed drivers, only indicate if a medical condition exists.

Systolic:	**Diastolic:**

DEPARTMENT USE ONLY SECTION			
RATER #:	**TRANSACTION TYPE:**	**TYPE:**	**MEDICAL DATE: MM/DD/YYYY**
	❑ ADD ❑ UPDATE	❑ A – SCHOOL BUS ❑ B – NOT STABLE ❑ D – STABLE	

CONTINUED ~ SECTIONS C, D & E – To Be Completed By Medical Examiner

SECTION C – Disabled Parking Plates

I hereby attest to the fact that at the time of the examination the applicant:

Check-mark the applicable disability. **One must be check-marked**.

- ❑ Has an irreversible visual impairment, or
- ❑ Has an irreversible ambulatory disability within the meaning of 23 VSA §304a.

SECTION D – Medical Examiner's Opinion

1. I have examined the patient and in my opinion: (Check-mark one of the statements below.)

   - ❑ The patient **IS NOT** medically fit to drive any motor vehicle on the highway.
   - ❑ There are no reasonable **medical** grounds to limit the driving privileges for a passenger car.
   - ❑ The patient is medically fit to drive, however, they should:
     - ❑ Submit progress reports to the Department of Motor Vehicles every: _____ Months _____ Years
     - ❑ Be further evaluated for driving ability.

   Comments:

2. **Patient's condition is totally stable:** ❑ **Yes** ❑ **No**

SECTION E – Medical Examiner's Certificate

THIS FORM MUST BE COMPLETED BY A LICENSED PHYSICIAN, EXCEPT AS STATED BELOW.

1. If the medical is for School Bus requirements, it must be signed by a Licensed Physician, Physician Assistant or a Nurse Practitioner.

2. If the applicant has or is applying for a Vermont license, without a School Bus endorsement, the medical must be signed by a Licensed Physician. **Exception:** A Physician Assistant may sign the medical, if co-signed by a Licensed Physician.

3. If the applicant is applying for Disabled Parking Placard or Disabled Parking Plates, the medical must be signed by a Licensed Physician, Certified Physician Assistant or Licensed Advanced Practice Registered Nurse.

I certify that the information contained herein is true, complete and correct to the best of my knowledge. Statements and warrants made herein are certified under penalty of 23 V.S.A. §202 & §203.

Date of Exam (MM/DD/YYYY)	Date of Exam Must be Entered at Left and be Within the Last 6 Months to be Acceptable.

Medical Examiner's Signature	Date

Medical Examiner's Name (Print Clearly)	Phone Number

Medical Examiner's Mailing Address	Street/Road/Box Number
	City/State/Zip Code

Classification Or Specialty	Title	License State	License #